Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JOHN A. SAZY, MD

Respondent Name
NATIONAL FIRE INSURANCE CO OF HARTFORD

MFDR Tracking Number
M4-13-1872-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
MARCH 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was a complicated, high complexity visit. All the key components and criteria required were more than adequately met. This should be paid."

Amount in Dispute: $285.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry has indicated that after further review of the rebuttal documentation from the provider, the denial of CPT code 99205 stands as the provider's documentation is lacking to meet the criteria of the CPT code 99205 as defined by the 12012 AMA CPT Standard Edition guidelines for E&M coding."

Response Submitted By: Law Offices of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2012	CPT Code 99205 Office Visit	$285.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150-Payer deems the information submitted does not support this level of service.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Issues

Does the documentation support billing of CPT code 99205? Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the office visit, CPT code 99205 based upon reason code "150."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99205 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family."

A review of the submitted medical reports finds that the requestor did not document a complete review of systems required in a comprehensive history; therefore, the requestor did not meet all the key components to support billing CPT code 99205 on the disputed date of service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/25/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.